STATE OF NEVADA
AGING AND DISABILITY SERVICES DIVISION

SERVICE SPECIFICATIONS
CASE MANAGEMENT

Any exceptions to these Service Specifications must be requested in advance in writing and approved by the Deputy Administrator.

PURPOSE:

To promote quality of service, the Aging and Disability Services Division (ADSD) has established service specifications that contain general guidelines. ADSD will use these service specifications as the basis for assessing program performance. The service specifications that each grantee must follow consist of GENERAL REQUIREMENTS, according to the funding source, and SERVICE-SPECIFIC REQUIREMENTS established for each funded service.

SERVICE DEFINITION:

This service is a process by which client needs (Activities of Daily Living and Instrumental Activities of Daily Living) are identified, and services to meet those needs are located, coordinated, and monitored.

SERVICE CATEGORIES AND UNIT MEASURES:

The following service categories and unit measures established by the Administration on Aging (AoA) must be used to document the amount of service provided:

Case Management: Assistance either in the form of access or care coordination in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, which require the provision of services by formal service providers. Activities of case management include assessing needs, developing care plans, identifying available providers, follow-up and reassessment, as required.

One unit equals one hour of service.

GENERAL REQUIREMENTS:

A. Case managers may also be Licensed Social Workers and would therefore need to meet the requirements of NRS Chapter 641B, Social Workers.

SPECIFICATIONS:

1. Eligibility:

1.1 Client must be functionally impaired to be eligible for case management services. Eligibility is based on an individual's ability to perform Activities of Daily Living (ADLs). These activities include eating, transferring, ambulating, dressing, bathing, toileting, and controlling bladder and bowel. In addition, the client's ability to perform Instrumental Activities of Daily Living (IADLs) will be considered. These activities include meal preparation, housekeeping, doing laundry, shopping, medication management, using the telephone, accessing transportation, and financial management.

2. Required Services:

2.1 A written screening procedure must be used to assess the appropriateness of the client referrals for the case management program.

2.2 The designated case manager must act as an advocate on behalf of the client/client's family with agencies and service providers.

2.3 Clients who appear to be eligible for the ADSD's Home and Community Based Waiver (HCBW formerly CHIP) must be referred.

2.3.a In the event that the HCBW program has a waiting list, the case manager must attempt to find an interim service.

3. Optional Service:

3.1 Transport of clients to apply for needed services may be provided as part of the case management service. The grantee must verify that caseworkers maintain a valid Nevada Driver's License and automobile insurance per NRS 485.185. All drivers must submit a copy of their driving record from the Department of Motor Vehicles, prior to hiring and annually, thereafter. Copies of the driving records of each driver must be maintained on file. A thorough fingerprint and background check must be completed on each caseworker.

4. Service Prohibitions:

4. 1 Staff shall not visit clients after the grantee's business hours without the supervisor's approval.

4.2 Staff shall not operate as the client's legal guardian or executor.

4.3 Staff shall not investigate suspected elder abuse, but must refer suspected abuse to the appropriate agency within 24 hours.

5. Assessment:

5.1 A standardized, multi-dimensional assessment of the client must be completed and must document:

5.1.a An appraisal of the client's support system;

5.1.b a description of the client's physical/mental health and ability to perform ADLs and IADLs; and

5.1.c a description of the client's home environment and financial resources.

5.1.c.1 If the initial assessment is conducted in a setting other than the client's place of residence, an assessment of the residence must be completed within 30 days.

5.2 A care plan must be developed with the client/client's representative that incorporates the client's goals and choices. The care plan must contain specific actions designed to meet the established goal(s), including the type, amount, frequency, duration, and sources of services to be arranged or provided. The care plan must be signed and dated by the client and/or caregiver and case manager. A copy of the completed care plan must be provided to the client or caregiver.

5.3 Amendments to the care plan must be made as necessary. At a minimum, a new care plan must be established annually.

5.4 A reassessment must be conducted at least every six months to assess any changes in the client's physical health, mental health, and/or support systems. The reassessment must include the following:

5.4.a A description of the client's ability to perform ADLs and IADLs;

5.4.b an evaluation of the services provided and the progress toward the goals established in the client's care plan;

5.4.c an assessment of the client's mental/physical condition and support system;

5.4.d an assessment of the services needed; and

5.4.e a summary of any changes to the client's condition since the last assessment, if any.

5.5 The client's condition must be monitored monthly by phone or in person. A home visit or a visit in an adult day care setting is required no less than every six months. The purpose of monitoring is to determine the appropriateness and

quality of the service and the status of the client's condition. Documentation must be maintained in the client's file.

6. Documentation Requirements:

6.1 In addition to the client assessment, care plan, monthly monitoring case notes, and reassessment, the file must include:

6.1.a Client referral information, including a minimum documentation of: date, name of agency contacted, name and title of person handling the referral, and the reason for the referral. A follow-up must occur within 30 days and note the outcome of the referral.

6.1.b Case narrative notes that document each contact with, or on behalf of, the client, including referrals and outcomes. Narrative notes must also include date of entry, brief summary of pertinent information, initials, and title of person making the entry.

6.1.c Statement of Understanding which explains the client's rights and obligations under the program (including grievance rights) and indicates the client's desire to receive services. The client must read this document or have it read to him/her. The form must be signed and dated by the client/client representative and the case manager. The client/client representative must receive a copy of the Statement of Understanding form.

6.1.d Copies of all applications completed on behalf of the client.

7. Training:

7.1 Any person providing case management services who is not licensed in accordance with NRS 641B, et sec., must receive at least 10 hours of training annually in areas related to case management.

8. Special Compliance Requirement:

8.1 Grantees must have current commercial and professional liability coverage as appropriate.